

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30979**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4103

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town) KANSAS CITY MO.		c. LENGTH OF STAY (in this place) 50 YEARS	
c. CITY OR TOWN KANSAS CITY		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		STREET ADDRESS (If rural, give location) 2437 E. 70th N.C. MO.	
3. NAME OF DECEASED (Type or Print) a. (First) JENNIE b. (Middle) MAUDE c. (Last) THOMSON		4. DATE OF DEATH (Month) (Day) (Year) 9-15-56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 1-8-81
9. AGE (in years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL 40 YEARS - CLERK COMMERCIAL TRUST CO.	
10b. KIND OF BUSINESS OR INDUSTRY COMMERCIAL TRUST CO.		11. BIRTHPLACE (City and State or Foreign Country) BRIDGEPORT OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME ABNER WELCH	
13b. MOTHER'S MAIDEN NAME JANE		14. NAME OF HUSBAND OR WIFE FREDRICK L. THOMSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 499-16-0548	
17. INFORMANT'S SIGNATURE OR NAME MRS. BEVERLY JEAN BUCHANAN		ADDRESS 2437 E. 70th ST. KANSAS CITY MO.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkin's disease	
II. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19a. DATE OF OPERATION 9-12-56		19b. MAJOR FINDINGS OF OPERATION Hodgkin's disease (abdominal)	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from June 1, 1956 , to Sept. 15, 1956 , that I last saw the deceased alive on Sept. 15, 1956 , and that death occurred at 6:40 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE Albert V. Wacker M.D. (Degree or title) 0		23b. ADDRESS 315 Nichols Rd. Kansas City Mo	
23c. DATE SIGNED 9-17-56		24a. BURIAL (REMOVAL) (Specify) BURIAL	
24b. DATE SEPT-18-1956		24c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
24d. LOCATION (City, town, or county) (State) INDEPENDENCE MISSOURI		25. FUNERAL DIRECTOR'S SIGNATURE D.H. Newcomer's Sons ADDRESS 1331 BAYSH CREEK KANSAS CITY MO.	
DATE REC'D BY LOCAL REG. 9-18-56		REGISTRAR'S SIGNATURE Neva Marshall	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD
Albert I. Decker

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Chester K. Brown*

Licensed Embalmer No. *493*

P.O. Address *K E W*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.